Profiles of Hope
Ron Henderson

Protease inhibitors and combination therapy are changing many lives. For the first time, people with HIV are progressing not from illness to death, but from illness to health. For some, this has raised confusing psychological responses. Many are less confident about the rosy predictions of a “cure” and have questions about the complexity of drug regimens, the risk of serious side effects, the expense of the medications, and the effect of new-found health on their everyday lives. For some, the new treatments have failed.

For people like me, this period of rapid change presents questions about what to do and what the future will bring. I’ve watched medical treatment evolve over the years that I have had HIV disease and been an HIV service provider, and yet, the most powerful influences on my own health care plan have been the choices and experiences of my friends. This article is a window into the lives of five people with HIV disease, people I know, who are facing these changes with excitement as well as apprehension. We all have been “infected” in unique ways by these hopeful times.

The New Numbers Game

This year I will be 45. I have been living with HIV since testing positive in July of 1985 and have worked in the epidemic as a volunteer, counselor, educator, and now as the director of a youth and HIV project in San Francisco. For 12 years, my T-cell count has averaged in the mid-300’s and I have never taken antiviral drugs. I received an AIDS diagnosis after a bout with esophageal candidiasis four years ago and have had hairy leukoplakia and chronic bronchitis. But, despite moments of fear and uncertainty, I have remained well while dozens of my family of friends have died. For me, the repetition of loss and grief has been the hardest part of living with AIDS. I moved to San Francisco in 1982 at the dawning of the AIDS epidemic; 12 years later, when I left, it was partly to escape the death and dying, but also to live out my final years in the beauty and peace of the Russian River, a more rural area an hour north of the city.

When I began writing this article, I had a viral load of 238,000.* It’s a new numbers game for me, but the anxiety associated with high versus low numbers is all too familiar. I have had four counts over the past year, and this last one is the highest. I struggle with what this count really means. From everything I have read and heard, it represents a threatening level of virus in my blood, yet I feel no different physically. Could it be that my luck and good health are coming to an end and that I am finally moving toward the inevitable opportunistic diseases and death? Or will my viral load vary as have my T-cell counts?

I have decided to wait and make a decision about combination therapies until after my next viral load count. This decision has taken some courage: I have had to resist the persuasion of colleagues and friends to jump in and start one of the new drug regimens. I have trouble reconciling the success of these new approaches with my 12-year, antiviral-free survival and my experience watching friends die even after aggressive use of antiviral drugs. I’m open to doing whatever it takes to remain healthy, but I have no sense of what my decision should be or how I will make it.

My first conversation was with Gary,† an enthusiastic 19-year-old who tested HIV-positive three years ago. As he began to accept his sexual orientation, he came to believe that being gay meant having AIDS. When he came out to his mother, she rein-

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*Viral load is the number of copies of HIV RNA per milliliter of blood. The higher the viral load, the more rapid the progression of HIV disease. Experts debate whether there is any "safe" viral load level below which the risk of progression is minimal and HIV treatment can be deferred. CD4+ ("T-cell") count is not necessarily the best indicator of when to begin treatment, but does indicate the health of the immune system. An HIV-infected person with a CD4+ count of 500 or more is considered to have a relatively healthy immune system.

†The names in this article are fabricated; the stories are true.
There is so much hope going around these days that this once potent term verges on the non-descript. Echoing in my thoughts is a line—suggested by therapist Jeanne Achterberg at a 1995 conference on hope and cancer—that I revisit like a mantra when I’m overwhelmed by media hyperbole: hope is the “enduring feeling that life makes sense.”

Sometimes it seems like decades since AIDS began—way, way, way back in early ’80s. I know so much about AIDS that I want to cry or laugh or just fall down exhausted, perhaps to dream, without ending up at someone’s bedside. Or at someone’s memorial making jokes because we’ve talked ourselves into believing that joy and fond memories are a part of the passage. I grieve only in my dreams, but I cry during sit-coms and at the sound of fire engines.

I’m not bitter, just distracted by the effort. I do believe in laughter, even in the face of death, and in memorials that make you shiver. But if these moments had been the only things that kept me going since 1982, when I started doing AIDS work, I would have stopped long ago—probably in 1983.

Gary’s uncertainty about HIV-related routine itself that has kept me going—but what could be more uncomfortable than watching people die again and again and having to read about it, write about it, and think about it.

Routine may have kept me on track in the direction I’ve traveled, but it wasn’t what inspired the journey. It must have been and still must be hope. Can hope become routine? I guess it must, by definition. So all the hype about hope is simply our collective toe stubbing—an event that reminds us that we’ve been hopeful all along, even though as the throbbing fades from consciousness we forget we have good things like toes and furniture.

The Seder is nothing if not a reminder of hope, a story about Moses leading the former Jewish slaves out of Egypt, a metaphor for affliction overcome and hope fulfilled. If AIDS has become routine, if words like “hope” and “cure” seem meaningless, it is the stories that people like Ron Henderson and Jeffrey Moulton Benevides tell in this issue of FOCUS that constitute a Seder: a reminder to me that the people almost absent have been restored and that their joy is my own. It’s also a reminder that through all of this, it is the stories we tell each other that embody the hope that keeps us going.

The Passover Story

Last month was Passover, a Jewish holiday for which I lay aside all my skepticism about religion, not necessarily to believe, but certainly to experience. Passover shares with other holidays a focus that defines the ritual: in this case, a meal and a story. But unlike any other religious holiday that I know of, Passover is about personal revelation, about annotating to a story that people have been repeating for 5,000 years.

This year the host of the Seder I attended assigned me Elijah’s Cup as my moment in the telling of the story to share. Elijah’s cup symbolizes hope, a reminder that when Elijah comes, a messianic age of peace will be attained. Elijah’s cup is also an affirmation of past hopes and their fulfillment, proof that hope is not the same as delusion. I talked about AIDS and the enduring feeling that life makes sense.

Since then, I’ve been wondering what about any of this has ever made sense. After 15 years, the effort has become routine; death has become routine; loss and mourning have become routine. I could argue the uncomfortable hypothesis that it is the routine itself that has kept me going—but what could be more uncomfortable than watching people die again and again and having to read about it, write about it, and think about it.

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Gary distrusts Western medicine, and while his doctor has educated him about his treatment options, he remains unsure about when to start and what option to choose. “Since I don’t know what to do, I do nothing.” With a T-cell count of 643 and a viral load of 4300, he feels he is doing well and that there is no urgency for him to begin taking drugs.

Gary believes that because he is young, many things in his life are changing and that being seropositive increases the difficulty of establishing career goals and negotiating intimate relationships. He worries that many of his peers who are seronegative are not being safe because they believe that HIV disease is treatable. He knows that he can take these drugs when he needs them, especially if his numbers change or he becomes ill. Still, Gary’s attitude has changed: “Two years ago I was doing whatever I had to do before I died. Now I am planning for the future.”

Gary’s uncertainty about HIV-related treatment may be partially related to his youth, yet I found myself identifying with
his reluctance to start drug therapy. Gary looks to me as an affirmative role model of an older gay man and a long-term HIV survivor, and our friendship has bridged the traditional age gap. I recognize the risk of Gary thinking that I have the magic formula for surviving with HIV, and I’m careful to encourage him to find his own answers.

Reclaiming Health

Billy, a thoughtful and bright acquaintance of mine now 25 years old, began routine HIV antibody testing when he was 20, always coming up seronegative. In October 1995, that changed. Billy’s counselor emphasized that HIV disease was not a “death sentence.” But Billy felt shock first and guilt later, blaming himself for not having known better, for having played the risk assessment game and lost. This is a guilt I don’t know, being from the generation of men infected before we knew HIV existed.

While Billy had understood about safer sex, he knew no one with HIV disease and was not involved in HIV-related community activities. Billy found a counselor who educated him about living with HIV, helped him gain a sense of control, and offered him referrals to other resources. Five months after testing HIV-positive, with a viral load of 186,000, Billy began taking an antiviral cocktail of zidovudine (AZT), lamivudine (3TC) and nelfinavir (Viracept). Billy believed that this was a “completely logical decision,” one he made with very little emotional distress. He worried about having no medical insurance, but found a study that would supply him with the drugs for free and pay for follow-up laboratory testing to monitor his progress.

Billy hates pills and drugs, and is scared by the knowledge that now that he has started drug therapy, he will never be able to stop. “I struggle with this… Sometimes I miss a dose, especially on weekends when I’m out at night. I refuse to carry a pill box. When I leave the pills at home it psychologically makes me feel like HIV doesn’t exist.” Initially Billy had problems with diarrhea and wondered whether it was all worth it. But his numbers have given Billy confidence: his viral load has become undetectable,* and his T-cell count has risen from less than 500 to 1,643. This change astonishes me as it is my first experience of knowing someone—whether on or off medications—whose health has improved so dramatically.

Billy believes that because he caught and suppressed HIV infection early, there is a chance he can eliminate it from his body, and this conviction keeps him motivated to take the drugs. He says that it is “weird” knowing that the virus is in his body doing nothing. Billy recognizes that the drugs are not a cure and he still has doubts: “It’s really hard because it’s all new. When I think about taking these drugs, it’s hard to know what my future will be.”

The recommendation of many medical experts to “hit hard, hit early” with combination therapies is disturbing to me. The purpose of this approach is to prevent any damage the virus might do. But unlike Billy, if I do decide to initiate antiviral treatment, I will be hitting “late,” having lived with the virus for more than a decade. At this moment, it is incomprehensible to me that I might be able to live virus-free. On the other hand, some theorize that since I am “treatment naive,” never having used any antiviral drugs, I may have an advantage over others who have taken antiviral drugs over the years. It’s confusing. Is the fact that I haven’t followed medical advice over the years now to my advantage? Why then would I believe medical experts now?

Searching for Definition

Dan is an exuberant and outspoken 34-year-old who lives with his dog and lover in the Castro, the heart of San Francisco’s gay community. He is currently on disability but is considering returning to work. He tested seropositive in 1990, and three years later, with a T-cell count of 30, received an AIDS diagnosis and disability status. He bailed out of work to enjoy some time before what he anticipated would be a period of decline towards death. Facing his own mortality, Dan felt old before his time. “I let go of the middle part of life and went into a sort of premature retirement.” HIV became the defining element in his life.

Dan is currently taking a triple combination of indinavir (Crixivan), stavudine (d4T), and 3TC and both his energy and his T-cell counts have increased. He embraces the “new treatment paradigm” but finds it represents a difficult adjustment. “If this is going to be a chronic manageable disease for me, then I have to think about managing this disease over a long period of time. There was some measure of comfort in knowing what I was going to die from and having a sense of an imminent time line.” Dan wonders how he will reinvest in life after making his peace with death and is challenged by the central fact that “that which I have waited for is not coming.”

*IAn “undetectable” reading means that the concentration of HIV in the blood is too low to be detected by the test. An undetectable result varies from one viral load assay to another; usually, it means that viral load is below 500. While it is an affirmation of health, it emphatically does not mean that there is no virus in the blood or that a person is uninfectious.
Dan believes that a “post-AIDS” culture is developing and that this is good. But he wonders what a life of rigorous pill taking will be like for people living with HIV disease. He wants to go back to work, but he is worried about how he will reinitiate his career. Dan had given up the idea of graduate school and was just beginning to explore work interests when HIV caused him to let go of planning and goals. Nonetheless, optimistic about the possibility of living for a long time, Dan is beginning to rebuild his life: “I have been in the land of the dying and the dead, and now my challenge is to rejoin the land of the living.”

I wonder if part of Dan’s questioning is also that of a man searching for direction and self-definition in his mid-thirties. Ironically, when I was Dan’s age, I had been seropositive for two years and was in my second year of graduate school. I too gave up the future I thought this degree might lead to, never completing my graduate studies. I remember clearly a well-meaning nurse telling me at the time that I should not worry, that I had a good three years to live. Dan’s reevaluation of his career has caused me to question if I might still have time to complete school, change my job path, and reinvent parts of my own life.

At 50 years old, Jason has lived with HIV disease since 1987, and has focused his efforts on alternative approaches, for instance, Eastern medicine, spiritual healing, nutrition, and stress reduction. When the news of protease inhibitors came out, Jason warned his positive friends, including me, not to be “brainwashed” by the reports.

Recently, Jason began to feel less well, and was shocked to find that his T-cell count had plunged to 120. Suddenly having an AIDS diagnosis, Jason submitted to triple combination therapy. The result has been dramatic: “I feel like a cloud has lifted and that my life force has returned.” Jason adds, “The way I see it, at the very least I’ve chosen short-term improvement over long-term misery...I am confident I’m going to be around for a long time.”

I have come to realize over the decade I have lived with HIV disease that a seriously weakened immune system or frightening symptoms often motivates aggressive intervention. While Jason continues to pursue alternative approaches, the ease with which he has incorporated combination therapies into his life has been one of the strongest influences in opening me up to the possibility of taking protease inhibitors.

Conclusion

Recent medical advances have changed our ability to manage HIV infection on a cellular level, but it remains to be seen how people will adjust the design of their lives. For many, these hopeful times require a new orientation to life, a reinvention of long-term goals, and an adjustment in one’s sense of identity. If we are the generation of people with HIV disease who are to survive, it is for us to redefine living with HIV as it evolves into a chronic manageable disease.

While writing this article, I received a new viral load count: 30,000—a drop of more than 200,000 from my last count. This news came as a shock, nonetheless confirming what has been true all along, that my experience is exceptional even among long-term survivors. When I got the results, I realized how much I had been living with a sense of doom, a belief that this next count would be yet higher and that I would need to begin the drug treatment I have so far resisted.

While antiviral therapy is less urgent for me now, I too have begun to see a future that is more open-ended and filled with renewed possibilities. I am beginning to believe that HIV disease doesn’t have to be in the way of my dreaming big dreams, that there is time for me to change and grow, that, for the first time, AIDS may not be the final chapter of my life story.

Clearinghouse: Treatment Experiences

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Anyone affected by HIV throughout the course of the epidemic has been engulfed by forces of doom and despair and, of late, has experienced the possibility for deliverance by the forces of hope and optimism. Never before in the epidemic has there been such a profound and sudden shift in perspective on life due to a medical advance: the success of combination therapy using protease inhibitors. In this article I examine the shared experience of both psychotherapist and client in response to this new landscape, paying particular attention to my own responses as an HIV seronegative therapist treating seropositive clients, primarily gay men.

For my clients and myself, the psychological response to the success of triple combination therapy evolved over time. At first, we embraced an uneasy calm as treatment—still too new to have proven itself—became more common. Despite our anticipation of promising treatments, therapy remained focused on the challenges of severe and unremitting HIV disease and the exigencies of dying. We questioned privately and aloud how any new treatment could really make a difference when so many drugs had provided false hope in the past.

As treatment progressed, my clients and I observed authentic and dramatic signs of their physical improvement and a corresponding shift in mood for both of us. Hope began to establish a stronghold in the therapeutic relationship. For most of my clients, hope was matched by an undisturbed and upward trajectory of physical and emotional health. For some, however, combination therapy failed to reduce viral load and boost CD4+ cell counts.

A Delicate Balancing Act

Holding both hope for continued health and fear of the possibility of antiviral failure has become a central focus of therapy. The work of therapy focuses on creating psychic space for ambiguity and uncertainty, hope and apprehension together. Supporting hope makes intuitive sense, but supporting apprehension is a less obviously beneficial goal. Given uncertainty about the long-term outcomes of combination treatment, however, holding apprehension as well as hope strengthens a client’s ability to tolerate reality, a crucial skill when reality becomes harsh or uncertain. Keeping each of these aspects alive—without collapsing into either polarized state—comprises the delicate psychic balancing act of therapy.

When this balancing collapsed under the weight of fear or ungrounded wishes, I have responded with disbelief and hopelessness. One client, Frank, who had an undetectable viral load and a normal CD4+ cell count, had become so certain that he had been “cured” that he actually believed he was seronegative, represented himself as such, and engaged in anonymous, unprotected anal intercourse. Frank’s response arose out of a psychological inability to hold simultaneously both hope—the good prognostic indicators—and dread apprehension—the possibility that the situation could reverse. Frank’s inability to consider the ambiguity...
of his situation left me fearful and uncertain. How could Frank have rediscovered a sexuality 14 years abandoned and put his sexual partners at such risk? In the end, I was left wondering whether I knew him at all and was disturbed by a feeling of impotence about not being able to help Frank respond differently. Fortunately, most of my clients have been able to hold ambiguity more successfully than Frank.

Uncertainty

I had hoped that health and the promise of an extended life would mean that the focus of therapy would shift, returning to the issues of living, and that in response, my role would also change. While I have been honored, at times, to embrace the role of a “handmaiden of death,” I have also felt constrained by the singular focus on end-of-life issues. This has meant that, as well as my clients, have experienced feelings of constriction, loss, and depletion—feelings that have ultimately become draining. With the success of combination treatment, I found myself anticipating the process of incorporating into therapy a dialogue about living, surviving, and dealing with issues concerning relationships and the future.

Some of my clients were pondering the same notions, but in the context of a question I had not expected: Is therapy even necessary now that illness, disability, and death were receding as therapeutic issues? This question was usually introduced by the client and, even though it happened several times, I always experienced it as a shock. I was struck by a different question: How could someone already in therapy not want to avail themselves of such a powerful process in reconstructing his or her life?

I found it an effective exercise in holding ambiguity—for myself as well as my clients—both to not know if therapy should or would continue and to move into the next phase of therapy. I suspected that some of those who did not want to continue therapy were experiencing a “flight into health,” a defense in response to the initial relief of a person’s symptoms. I understood that by removing such a stressor as HIV progression, someone might feel ready to leave therapy. But I wondered how anyone could integrate the dramatic change from being ill and near death to feeling well and then believe that the work of therapy could be finished.

An emerging identity can be undermined if client and therapist do not consciously negotiate its integration. As clients reclaimed health, I wondered who each had become as a result of the physical and psychological turmoil of being HIV-infected and if there were lessons he or she had learned that might be applied to new life and identity. Throughout, I sought to support our dyad’s ability to experience the angst generated by rapidly occurring and disruptive external events. I tracked my own and my client’s premature solidification of his or her new identity. For example, I alerted myself to the fact that some clients started to think of returning to previously unhappy jobs for lack of fresh ideas and confidence about what to do next.

Conclusion

Not surprisingly, as my clients began to reclaim their lives, I experienced a sudden desire to work less, explore interests put on hold for years, and reorient my life toward a greater balance of work and play, caretaking and creative pursuits. I became aware of how stoic I had become. Many other factors coalesced to motivate these changes, but it was the medical breakthrough of combination therapy that provided the last bit of leverage for this psychic shift. My rekindled exuberance has been freeing, but as do my clients, I must hold simultaneously the desire to experience unbridled optimism and the fear that treatment advances may not endure.

Holding paradoxical needs and wishes in a time of radical transformation demands much of the human psyche. It is likely that this balance will collapse in times of great despair or great relief. But, failure to hold this balance can lead to shifting back and forth from manic enthusiasm to dread in the anticipation of an unpredictable reality. The dialogue implicit in the therapeutic relationship makes psychotherapy the ideal place to acknowledge and hold imbalance—for both client and therapist.
Recent Reports

A Period of Grace

I have a feeling that I wouldn’t be around to enjoy this new attitude of hope if I hadn’t decided to take the triple combination therapy. There was a time when I would not take antivirals (AZT, d4T, 3TC, etc.). I was content to do my acupuncture and herbs, exercise, eat well, and have a positive attitude. This, I was certain, would keep me healthy and alive. Then my friends who were my role models for alternative treatments started to die. Then my quality of life started to decrease because I was sick all the time.

My nurse practitioner had not felt good about my decision not to take antivirals and never stopped suggesting that I try them. Once my CD4+ (T-cell) count was less than 50 I figured it was pointless anyway. What I knew of the research on antiviral therapy was that you had to have some T-cells for them to go up. (Not so with protease inhibitors.) Finally, last fall I ran into a woman who told me she was taking d4T and 3TC and having success in her blood work with no side effects. I decided that as long as I didn’t have to take AZT I would try it. I was only on the antivirals about 4-6 weeks when my N.P. suggested that I enroll in the expanded access trial for Crixivan. After a lot of questions, to my friends, Project Inform, AIDS Treatment News, and other service providers, I decide to give Crixivan a try. This was a long process, and if I make it sound simple I need to emphasize that it was not. I have always been suspicious of so-called AIDS drugs. I have seen the side effects and thought the benefits did not out-weigh the risks. But I came to a place where I needed to change my thinking.

In some ways, I am waiting for the Crixivan honeymoon to end. In the back of my mind I wonder, what are the side effects of long-term use of protease inhibitors? What creepy things am I going to read about or experience next year? When I find myself in that place, I try to tell myself to get out of there. Ignore the future, forget the past, enjoy the present.

Retracting My Obituary

It would be some kind of yuppie whine to complain about how burdensome it is to swallow a lot of pills on a complicated schedule, particularly if they keep you healthy. It isn’t all that difficult. But you can plan a slow day entirely around taking medicine...

My very first viral load test, taken before I went on Invirase, was only 5,795, which is very low, even with treatment. A viral load test of 5,000 is correlated with a 100 percent chance of surviving five years; at 100,000, you are in bad shape.

I stopped the presses on my obituary. After several weeks on the new therapy, I also started feeling well, better than I had in 10 years. I started gaining weight, 25 pounds to date. I no longer was fading...

But I’m not out of the woods. This treatment needs monitoring. My second viral-load test, after a month on Invirase and the other drugs, was 470, a spectacular decrease. But my third and fourth tests taken 10 weeks apart showed increases in viral load of 1,000, then to 2,000. The number was still low but headed in the wrong direction.

On June 26, [my doctor Jerry Groopman] doubled the Invirase to 3,600 mg a day (18 big yellow and green capsules). In August, he added the just-approved Roxane Laboratories drug Viramune, which is like AZT and 3TC but different; it is a “non-nucleoside.” In September, Jerry took me off AZT, which may have played itself out after four years, and substituted the Bristol-Myers Squibb drug Zerit (D4T), another drug in the same class. The viral load on September 3 had come down to 600. “An A+,” Jerry said.

The battle plan has been to move to Norvir or Crixivan if the AIDS virus is still detectable. I won’t get my October 29 results until next week. The goal is to get the viral load down to a level that can’t be measured, so as to reduce the likelihood that the virus will mutate into a drug-resistant form.

Perhaps the best news I’ve had is that my T4 cells rose over six tests from 157 to 292. The new drug “cocktails” haven’t been resoundingly successful in raising the T4 counts of patients with truly devastated immune systems, even when viral loads decrease. But 292 is a level that can probably sustain me...
Last week, on my sixth visit to Dr. Groopman's office in Boston, I had an hour to kill in his waiting room to read an issue of Poz—a magazine for the HIV-positive—and to watch eight or ten other AIDS patients coming and going. The extraordinary thing about the scene was that almost everyone was smiling, almost constantly.

People in doctors' offices had always struck me as bored or frightened. These men bantered with Nancy Leary, the secretary, smiling all the while. The fellow sitting nearest me stepped to the desk to speak animatedly on the phone about his Crixivan prescription.

Ten months ago, he was skeletal. He had an infection and his doctor believed he had weeks to live. Now, thanks to Crixivan, his viral load is too low to count, and he looks like the professional model he once was, handsome and healthy. To see him, you would have no idea he had AIDS or, as he said, that "this has been going on for about 10 years." I told him that I believe I was infected in 1982. "You’re lucky," he said. "Most people infected that long ago are dead."

**Personal Tales**


**David:** The last 2 years have been a rough ride. My CMV and KS nearly had their way with me 6-8 months ago. I'd been on AZT and saquinavir; I tolerated the AZT but not the saquinavir. I started 3TC about a year ago, which has been well tolerated. In April, I started Crixivan. I got a little rash, had to drink plenty of water; I experienced sleeplessness (take restoril nightly). Two months ago I began Viramune.

Developed a rash that is gradually dissipating. Ironically, six months ago I began a dramatic recovery. I still have KS but seem to be holding it at bay. CMV, too. Viral load 5 months ago was 36,000. Last month it was up to 121,000. If it's the same or higher this week, we will change from Crixivan to another yet undecided PI. My doctor and I don't place much value in a T-cell count. Last one was 8-9 months ago, at 12. But I tell you, I haven't looked or felt this good in two years. Hope it keeps up until we conquer this damn disease.

**Dan:** In June of 1992, I was infected with HIV. My T-cells took an immediate nose dive and in December of 1994 I was admitted to Cedars Sinai hospital with walking pneumonia. At the time I was told I had 13 T-cells and was diagnosed with AIDS. Since that time, everything has been an extremely hard uphill battle. I lost my place in Los Angeles, moved home to Delaware with my parents, hated that, then moved to Santa Fe, New Mexico. I was always dealing with one complication after another, the last one being a MAC infection.

My viral load in January was 116,000 and my T-cells were 5. My doctor at the time, Trevor Hawkins, stressed immediate action and started me on d4T and 3TC in early February. In March the viral load was 186,000 and the T-cell count 30. We waited for Merck's drug to be available and last April, I added Crixivan to the two other drugs. So far my viral load has been undetectable since June. The last time my T-cells were checked in August, I had 68. My weight last March was between 125 and 130 lbs.; it is currently about 155 lbs. My energy has returned to normal. I sleep though the nights for the first time in two years, and I have experienced no adverse side effects to any of the drugs. Also my last MAC culture came back negative.

Finally, for the first time in two years, I have been able to return to the business of living and let go of the prospect of dying anytime too soon.
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